MED Form Version 3.0
7/1/2001

Background Information:
Section A.6B – Program Assessment Requested
Changed #7 Alpha 1 Waiver to #7 Phys. Dis. Waiver (Physically Disabled)

Added: #27 PDN Medication Services*
#28 PDN Venipuncture Only*
#29 Consumer Directed HBC

***NOTE: For Section 96 – Medication, Venipuncture Only Services use #28 or #29 for these PDN referrals. Do not any longer use LTC Advisory (#1) for type of assessment requested.**

Section A.13. – Potential Payment Source
b. Changed Waiver for elderly to Waiver – Elderly, ADW
c. Changed Waiver for disabled to Waiver – Phys. Dis.

Clinical Detail: No changes in content. Tool appears different in this section due to changes in the font size and formatting only.

Eligibility Determination pages: Scoring has been revised to comply with recent policy changes in eligibility criteria. The order of programs has been reorganized with additional programs added.

Home Based Care: Scoring for the four levels of Home Based Care included.

Cognitive Capacity scoring on page 3 of 6. The voucher option offered by EIM under Home Based Care, BEAS Homemaker voucher option, and the Consumer Directed programs authorized by Alpha One now require determination of the consumer's cognitive capacity to self-direct their care as part of the eligibility determinations.

Consumer Directed Programs: scoring for consumer directed program/funding sources follow the Cognitive Capacity scoring in Eligibility Determination section (on page 3 of 6).

- Consumer Directed PCA
- Consumer Directed HBC
- Physically Disabled Waiver

Community Options Coding Sheet: Codes have been added on the coding sheet to be used when developing the care plan and filling in the Outcome page.

Program/Funding Source: #29 Consumer Directed HBC has been added.

Unit Code: #13 and #14 PRN Hour and PRN Visit
There are two new unit codes: one for PRN hour, one for PRN visit. PRN unit code is an available choice when policy allows for authorization of unscheduled or one time exception for service.
Examples:

- Indicated on referral for unscheduled visits of professional staff.
- Consumer treatment plan requires additional visits on an 'as needed' basis
- RN for catheter change 1x month and PRN as needed.

- Consumer needs authorization for one time additional service
- Transportation by PCA to MRI- requires PCA spend additional 2 hours between 7/15/00 and 7/31/00 to accompany consumer to MRI

Reason Codes: #32-63 have been added to better target specific care needs.

- New ADL and IADL reason codes (#32-46) replace the old collapsed ADL, IADL codes
- Note codes #47-62 mirror the HCFA 485s and may also be used to identify specific nursing tasks authorized under other program funding sources.
- Code 9 - use only when personal hygiene is a covered service
- Code 45 - transportation to medical appointments- this means transportation for medical care only
- Code 46- transportation for non -medical careplan needs- use this when PCA or CNA reimbursed for mileage to get careplan done
- Mileage has to be authorized on careplan
- Code 3 – use ONLY for care management functions for Alpha One administered programs
- Code 11 - paying bills- use ONLY when PCA/CNA has authority to perform this function
- Code 26 – use ONLY for service category #11-Medicaid Day Health or #12-Adult Day Care
- Code 27- use ONLY for night PCA services as defined in Sections 12, 22, and 73.

Reason codes provide audit trail on what tasks have been identified as a need and which provider will deliver the covered service. Audits by CMS (HCFA) require that specific reason codes match tasks documented as completed. BEAS and SURS audit based on authorized careplan reason codes.
Hours are authorized to complete tasks that are covered services. Consider tasks that are done concurrently.

Denial Codes: #6 and #7 have been added as Action codes and #14-19 have been added as reasons for change/reduction/termination/denial.

Section S. Support Services: Hours of care provided by family, friends, and other caregivers must be documented. Informal support is care provided that is **NOT** reimbursed by a formal program/funding source. For all programs, when informal support is being provided to meet identified needs covered as a service under that program, Section S.4 (and S.5 if two key helpers) will be filled in with hours provided that are not reimbursed. Paid caregiver hours are **NOT** informal support. Informal supports provide services needed by consumers to assure health and welfare in addition to formal supports and are integral to the success of home care programs.

Also S.7 Careplan will have:

- Program funding source = Other
- Service Category = Family or Friend
- Reason Codes as applicable
- Number of hours and frequencies, as noted on the Support grid.
- Hours for ADL, IADL, and Supervision when provided for safety

Assessor notes will provide pertinent details concerning ADL and IADL support given

Outcome page:
Section T.3 - #29 Consumer Directed HBC has been added to the second column.

The instruction manual for the MED form has been updated to reflect these changes to the form and recent changes in policy.